

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/17/2013
NAME OF PROVIDER OR SUPPLIER HARBOR LIGHT HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1841 E SUMMIT ST CROWN POINT, IN 46307		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 000	<p>INITIAL COMMENTS</p> <p>This visit was for a Hospice federal and state complaint investigation survey.</p> <p>Complaint #s IN00128016 - Unsubstantiated: Allegation did not occur. IN00124006 - Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey date: 5/14/13 - 5/17/13</p> <p>Facility #: 009088</p> <p>Medicaid Vendor: 200121780A</p> <p>Surveyor: Ingrid Miller, MS, BSN, RN, Public Health Nurse Surveyor</p> <p>Census: 757 skilled unduplicated admissions for past year</p> <p>Harbor Light Hospice is in compliance with the Conditions of Participation 42 CFR 418.52: Patient Rights, 42 CFR 418.54 Initial and Comprehensive Assessment as related to these complaints, 42 CFR 418.56 Interdisciplinary group, care planning, and coordination of services, 42 CFR 418.102 Medical Director, and 42 CFR 418.102 Clinical Records as related to these complaints.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 23, 2013</p>	L 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.